Payment 2

LTCH PPS Payment

Payment concepts and examples

Objective

The objective of the Payment chapter is to provide information that is needed to understand and compute the payment due to Medicare providers under the Prospective Payment System for Long-Term Care Hospitals (LTCH PPS).

Participants will learn about the following information in the course of this chapter:
The LTCH PPS will be phased in over a five-year transition period from cost-based reimbursement to prospective payment.
Patient classification system utilizing ICD-9-CM codes will assign a Long-Term Care diagnosis-related group (LTC-DRG) based on date of discharge.
Payment rates will be based on a single standard Federal rate for both inpatient operating and capital-related costs (including routine and ancillary services).
Certain pass-through costs (i.e., bad debts, indirect medical education and blood clotting factors) are not included in LTCH payment rates.

Background

The LTCH PPS replaces the existing reasonable cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) payment system under which LTCHs are currently paid.

LTCHs are certified under Medicare as short-term acute-care hospitals which have been excluded from the hospital inpatient PPS under § 1886(d)(1)(B)(iv) of the Social Security Act, and for the purpose of Medicare payment are defined as having an average inpatient length of stay of greater than 25 days.

Statutory Requirements

The BBRA of 1999, as amended by BIPA of 2000, mandates that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for **cost reporting periods** beginning on or after **October 1, 2002**, to replace the reasonable cost-based TEFRA payment system.

LTCHs Defined

Long-Term Care Hospitals (LTCHs) that are subject to the requirements of the LTCH PPS meet all of the following criteria:

- They are certified under Medicare as short-term acute-care hospitals, which have been excluded from the inpatient acute care hospital prospective payment system (IPPS).
- They meet state licensure requirements for acute care hospitals under section 1886(d)(B)(iv) of the Social Security Act.
- They are not excluded LTCH units in a facility, although they can be a satellite and/or hospital-within-a-hospital, co-located within another facility.
- LTCHs are identified by the last four digits of the Medicare provider number, which range between "2000" and "2299."
- They have a provider agreement with Medicare in order to receive Medicare payment.
- They have an average length of stay for Medicare patients of greater than 25 days. or
- The hospital has been exempted from certain of these general LTCH requirements by §1886(d)(1)(B)(iv)(II) of the Social Security Act (implemented by 42 CFR §412.23(e)).

Hospitals Not Subject to LTCH PPS

Some hospitals are paid under special payment provisions and are therefore not subject to LTCH PPS.

The following hospitals are paid under special payment provisions and, therefore, **will not be subject to the LTCH PPS rules:**

- Veterans Administration hospitals
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act)
- Two of the four Maryland LTCHs included on CMS's OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore are not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center (#212005) and Deaton Hospital and Medical Center (now know as University Specialty Hospital, #212007).
- Foreign hospitals, which will continue to have payment, made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c).
- Nonparticipating hospitals

Average Length of Stay

The methodology for determining ALOS at an LTCH is **changed.**

LTCHs are certified under Medicare as short-term acute-care hospitals and, for the purpose of payment, are defined as having an average inpatient length of stay of greater than 25 days.

CMS has changed its methodology for determining the average inpatient length of stay to exclude non-Medicare patients. However, it is not changing the methodology for counting both covered and noncovered Medicare days when calculating whether the LTCH meets the 25-day average length of stay.

For cost reporting periods beginning on or after October 1, 2002, the LTCH average length of stay is based on the hospital's Medicare inpatients' total medically necessary days, which will include Medicare covered and Medicare noncovered days.

Previously all days for both Medicare and non-Medicare were used to determine the hospital's average length of stay. The revised criteria will be in effect for LTCHs for their first cost reporting period that begins on or after October 1, 2002 using the same procedures employed by the FI under the previous payment system.

Qualifying LTCHs Under PPS for ALOS

For cost reporting periods beginning on or after October 1, 2002, LTCHs must meet this revised qualification established under the LTCH PPS that counts only Medicare patients in the average 25-day ALOS calculation. Only hospitals qualifying as LTCHs under revised criteria will be subject to LTCH PPS for their first cost reporting period that begins on or after October 1, 2002.

Fiscal Intermediaries (FIs) must determine whether existing LTCHs qualify for payments under LTCH PPS according to revised criteria after October 1, 2002. The FI will review the LTCH's discharge data from its most recent cost reporting period to determine if it satisfies the new criteria. If the FI determines that the LTCH will not qualify, FIs will follow procedures already established in section 3001.4 of CMS Pub. 15-1. Further instructions will be forthcoming.

FIs must notify LTCHs whether the LTCH qualifies for payment under the LTCH PPS before the start of the LTCH's next cost reporting period. Each LTCH will undergo an ongoing monitoring and notification by FIs regarding compliance with the 25-day ALOS.

Medical Necessity and the LTCH's ALOS

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical

necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule. In such case, the **days of a stay failing medical review will be excluded from the provider's 25-day average length of stay computation** for the LTCH's cost reporting period.

Determining and Maintaining LTCH Status

Ordinarily, the determination regarding a hospital's average length of stay is based on the hospital's most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six-month period are used. (See CMS Pub. 15-1, PRM 1, 3001.4)

Payment Provisions of the LTCH PPS

Note:

BIPA confers broad authority to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, in order to ensure that payment most accurately reflects cost

LTCH PPS applies to inpatient hospital services (operating and capital) furnished by Medicare participating entities that have been excluded from the acute care hospital inpatient prospective payment system (IPPS) as LTCHs.

Medicare Part A costs not paid for under the LTCH PPS are subject to the interim payment provisions. Examples of these costs include:

Medicare costs of an approved medical education program,

Bad debts,

Blood clotting factors,

Anesthesia services by hospital-employed non-physician anesthetists or obtained under arrangement, and

Costs of photocopying and mailing medical records requested by a QIO/PRO.

Prior to October 1, 2002, each LTCH was paid on a hospital-specific basis under the TEFRA system. When PPS is totally phased-in, after the five-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a "standard Federal rate."

A Medicare patient in a long-term care hospital is considered discharged when:

For purposes of the long-term care hospital qualification calculation, as described in Sec. 412.23(e)(3), the patient is formally released;

For purposes of payment, as described in Sec. 412.521(b), the patient stops receiving Medicare-covered long-term care services; or

The patient dies in the long-term care facility.

Budget Neutrality

Total payments under LTCH PPS must equal the amount that would have been paid if the PPS had not been implemented. The standard Federal rate was determined based upon this statutory requirement. In addition, behavioral changes following implementation of the LTCH PPS were taken into account.

The budget neutrality offset for FY 2003 is 0.934.

An additional offset is based on payment calculations related to actuarial estimates of the number of LTCHs that will elect to be paid blended payments vs. 100 percent Federal prospective payments will be applied to each Medicare payment.

The reduction factor for LTCH payments during the transition period accounts for the monetary effect of the five-year transition from the present cost-based payment system to LTCH PPS including the fact that a certain number of LTCHs will opt for an irrevocable election to be paid 100 percent under the LTCH PPS.

For LTCHs paid under the transition blend methodology (discussed in the Facility-Level Adjustments section), the budget neutrality offset will be applied to **both** the reasonable cost-based TEFRA rate percentage and the Federal rate percentage.

The offset will also be applied to all payments to LTCHs electing payment under 100 percent of the Federal rate.

The budget neutrality offset equals one minus the ratio of the estimated TEFRA reasonable cost-based payments (that would have been made had the LTCH PPS not been implemented) to the projected total Medicare program payments that would be made under the transition methodology including the option to elect payment based on 100 percent of the Federal rate.

The budget neutrality offset for FY 2003 is 0.934. That is, **all** LTCH PPS payments in FY 2003 will be reduced by 6.6 percent.

Calculating an Unadjusted LTCH Prospective Payment Rate

An unadjusted Federal PPS rate is the product of the LTC-DRG relative weight and the standard Federal rate.

Payment under the LTCH PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular Long-Term Care Diagnosis Related Group (LTC-DRG), the weight of the LTC-DRG and Federal payment rate. These factors are used to calculate an unadjusted LTCH PPS rate. An unadjusted Federal PPS rate is the product of the LTC-DRG relative weight and the standard Federal rate.

Patient Classification System

The BBRA required the use of diagnosis-related groups (DRGs) for patient classification purposes in the PPS for LTCHs.

Cases are generally grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings or **LTC-DRGs** are based on the existing the Case Mixed Groups (CMGs) and DRGs used in the IPPS.

LTCH patient discharges will be grouped using:

ICD-9-CM codes based on the principal diagnosis,

Up to eight additional diagnoses, and

Up to six procedures performed during the stay, as well as

Age,

Sex, and

Discharge status of the patient.

GROUPER

LTCH PPS will use the same GROUPER software developed by 3M for the IPPS for FY 2003 (currently Version 20.0), but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients.

Relative weights will be updated annually using the most recent available LTCH claims data.

PRICER

LTC-DRG relative weights and the geometric average lengths of stay are maintained in the LTCH PRICER program. Payment for short-stay outliers is also determined in the PRICER logic. This program calculates the Medicare payment rate using the following data:

LTC-DRG assignment made by the GROUPER

- Standard Federal rate
- Applicable facility-level adjustments
- Applicable case-level adjustments
- The applicable five-year phase-in period blending ratio for those providers that choose to be paid on the blended rate.

Payment for interrupted stay cases will be handled with billing instructions, not PRICER. Payments based on the co-located policy will be determined at cost-report settlement.

PRICER Inputs

Provider Specific File Data (§3656.3 and §3850 of the MIM); Fields-3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19 (five-year blend or may choose 100%), Fields 21*, 22, 25 (although this field refers to the operating cost/charge ratio, for LTCH, data entered here will be a combined operating and capital cost/charge ratio.)

Provider #	Length of Stay (LOS)
Patient Status	Covered Days
Covered Charges	Lifetime Reserve Days (LTR)
Discharge Date	DRG (from Grouper)

* Field 21 refers to facility-specific rate and will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS was not being implemented.

PRICER Outputs

PPS Return Code	Regular Days Used
MSA	LTR Days Used
Wage Index	Blend Year, 1-5
Average LOS	Outlier Threshold
Relative Weight	DRG
Final Payment Amount	COLA
DRG Adjusted Payment Amount	New facility- specific rate
Federal Payment Amount	Calculation Version Code
Outlier Payment Amount	National Labor Percent
Payment Amount	National Non-Labor Percent
Facility Costs	Standard Federal Rate
LOS	Budget Neutral Rate

Relative Weights

Payment weights assigning a specific value representing the relative resource use of each LTC-DRG were determined by the "hospital-specific relative value method."

This methodology normalizes charges within each hospital and then compares them across hospitals.

Relative weights will be updated annually using the most recent available claims data.

Payment Rate

There is a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors).

The FY 2003 LTCH PPS the standard Federal rate, prior to facility-level adjustments, is **$34,956.15**.

The standard Federal rate will be updated annually by the excluded hospital with capital market basket index.

The formula for computing an unadjusted LTCH PPS prospective payment is:

Unadjusted Federal Prospective Payment =
LTC-DRG Relative Weight * Standard Federal Rate

LTCH PPS Payment Adjustments

Payments will be based on the LTC-DRG assigned as well as possible adjustments specific to the case and/or the facility.

LTCHs are distinguished from other inpatient hospital settings by serving patients that require an average length of stay of greater than 25 days, thus case-level adjustments for certain cases that have stays of considerably less than the average length of stay were established.

More than one case-level adjustment may apply to the same case.

Case-level adjustments established in the LTCH PPS include:

Short-stay outliers

Interrupted stays

High cost outlier cases (i.e., that exceed the outlier threshold)

Note

Unlike IRF PPS, there is **no** special payment policy for transfer cases or deaths.

The LTCH PPS also includes several **facility-level adjustments.** The facility-level adjustments include adjustments for:

The area wage index

The cost of living adjustment (COLA) for LTCHs in Alaska and Hawaii

There is also a payment policy for LTCHs co-located with other Medicare providers.

The **LTCH PPS does not include** any of the following "typical" adjustments found in other prospective payment systems:

Rural location

Geographic reclassification

Disproportionate Share (DSH)

Indirect Medical Education (IME)

Short-Stay Outliers

CMS has established payment categories for certain cases that have stays of considerably less time than the average length of stay, known as "short-stay outliers." The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment.

Definition

A short-stay outlier is a case that has a length of stay **between one day and up to and including 5/6** of the average length of stay for the LTC-DRG to which the case is grouped.

Payments for short-stay outliers are determined in the PRICER logic.

A short-stay outlier case is paid the least of:

The **full** LTC-DRG payment;

120 percent of the LTC-DRG specific **per diem** payment. (The per diem amount for short-stay outliers for each LTC-DRG is calculated by dividing the full LTC-DRG payment by the average length of stay for the LTC-DRG, and multiplying by the length of stay of the case.

120 percent of the **cost** of the case (determined using the hospital-specific cost-to-charge ratio (CCR)).

Short Stay Outlier Computation Example

Use this background information to follow the short stay outlier computation example which follows.

The patient was in the LTCH for **10 days** (LOS). Upon discharge the patient had incurred $13,870.33 in charges and the services provider were grouped to LTC-DRG 113.

The relative weight of LTC-DRG 113 is relative weight is 1.4103 and the average length of stay (ALOS) for LTC-DRG 113 is 36.9.

The provider's cost-to-charge-ratio (CCR) is 0.8114 and is located in an MSA, which has a 1/5 wage index of 1.0301.

To Compute the Full LTC-DRG Payment:

((Standard Federal Rate x Labor percentage) x (1/5 Wage Index Value) + Non-labor Share) x LTC-DRG Weight

$34,956.15 (standard Federal rate)
x 0.72885 (labor %)
$25,477.79 (labor share)
x 1.0301 (1/5 wage index value)
$26,244.67 (wage adjusted labor share)
+ 9,478.36 (non-labor share=$34,956 x 0.27115)
$35,723.03 (adjusted standard Federal rate)
x 1.4103 (LTC-DRG 113 relative weight)

$50,380.19 (Full LTC-DRG payment)

To Compute 120% of the Specific LTC-DRG Per Diem:

Full LTC-DRG Payment x LOS of the case x 1.2
ALOS LTC-DRG

$50,380.19 (full LTC-DRG payment as calculated above) = $1,365.32
36.9 (ALOS LTC-DRG 113)

$1,365.32
x 10 (LOS)
$13,653.20
x 1.2

$16,383.80 (120% of per diem)

Short Stay Outlier Example Resolution:

In the example, the case would be paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

To Compute 120% of Cost:

Charges x CCR = Cost

($13,870.33) x (0.8114) = $11,254.39

120% of cost = $11,254.39 x 1.2 = $13,505.27

Interrupted Stays

An interrupted stay is defined as a case in which an LTCH patient is admitted upon discharge to an inpatient acute care hospital, or inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed hospital and returns to the same LTCH within a specified period of time.

Acute care hospital = **9 days or less**

Inpatient Rehabilitation Facility (IRF) = **27 days or less**

Skilled Nursing Facility (SNF) = **45 days or less**

Swing-bed hospital = **45 days or less**

If the length of stay at the receiving provider is equal to or less than applicable fixed period of time, it is considered to be an interrupted stay case and is therefore treated as a single (one) discharge for the purposes of payment.

Only one LTCH PPS payment will be made.

Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions. It is possible that a beneficiary's stay at an LTCH may be interrupted multiple times. Each interrupted period that occurs should be evaluated individually regarding the number of days at the intervening facility to determine if it meets the requirements of the interrupted stay policy. Any interrupted period that meets the interrupted stay policy requirements should be entered as one claim, but represented with multiple occurrence span codes of 74.

Three common situations **do not meet** the definition of an interrupted stay under LTCH PPS:

1. Length of stay at "receiving" site of care exceeds the above listed fixed periods of time; the return to the LTCH will be a **new "admission."**

- For example, patient is discharged from the LTCH and then admitted to an acute hospital. The patient then returns to the same LTCH in 10, 11, 12 or more days. The return to the LTCH will be a new admission and billed as such.

2. "Receiving" site of care is not an acute care hospital, an IRF or a SNF/swing bed; the return to the LTCH will be a **new "admission."**

- For example, patient is discharged from the LTCH and then admitted to care provided by an HHA; any return to the LTCH will be a new admission and billed as such.

3. Patient is admitted to more than one facility or goes home between LTCH stays; the return to the LTCH will be a *new admission*.

- For example, if the patient is discharged from the LTCH, admitted to an IRF, and then the IRF discharges the patient to an acute care hospital and finally, the acute care hospital discharges the patient to the original LTCH, the return to the LTCH will be a new admission and billed as such.

In all three of these situations, which **do not meet the definition of an interrupted stay**, the original discharge from the LTCH to the other provider will be treated as a discharge for payment purposes. The second stay at the LTCH will also be treated as a discharge for payment purposes. **Therefore, two separate payments will be made to the LTCH.**

If the length of stay at the receiving provider falls within the fixed periods of time **and** the Medicare beneficiary did not either go home or to yet another facility before returning to the LTCH:

The original stay and the second stay that occurs upon the return to the LTCH should be billed to Medicare on one claim.

The claim must reflect the interrupted period of time.

The first bill should be cancelled if it has already been submitted and processed.

Note: An interrupted stay at an LTCH can also be a short-stay outlier.

If length of stay at the receiving provider falls outside the fixed periods of time or the Medicare beneficiary did go home or to a third facility before returning to the LTCH:

The original stay and the second stay that occurs upon the return to the LTCH are separate, in other words, **not interrupted**. Therefore, two separate claims should be submitted.

For the percentage of payments that will be made under the TEFRA system during the blended payments of the five-year transition to the standard Federal payment rate, the FI will treat each segment of the interrupted stay as a separate discharge. (FIs should follow the same procedure as under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

The following examples illustrate several scenarios related to interrupted stays.

Example #1-A:

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to an acute care hospital on October 10, 2002.

Day count of the interruption begins on October 10, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the ninth day after discharge, which is October 18, 2002.

The patient's stay at the LTCH may be paid as a short-stay outlier since it was only five days prior to the discharge.

If it is an interrupted stay and the stay following the readmission to the LTCH is greater than 5/6 of the ALOS for the LTC-DRG, then the stay will generate a full LTC-DRG payment.

Example #2-A:

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to an IRF on November 30, 2002.

The day count of the interruption begins on November 30, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 27th day after discharge, which is by December 26, 2002.

Example #3-A:

Patient is admitted to an LTCH on October 5, 2002.

Discharged from the LTCH and admitted to a SNF on October 10, 2002.

The day count of the interruption begins on October 10, 2002.

To meet the criteria of an interrupted stay, the patient would have to return to the same LTCH by the 45th day after discharge, which is November 23, 2002.

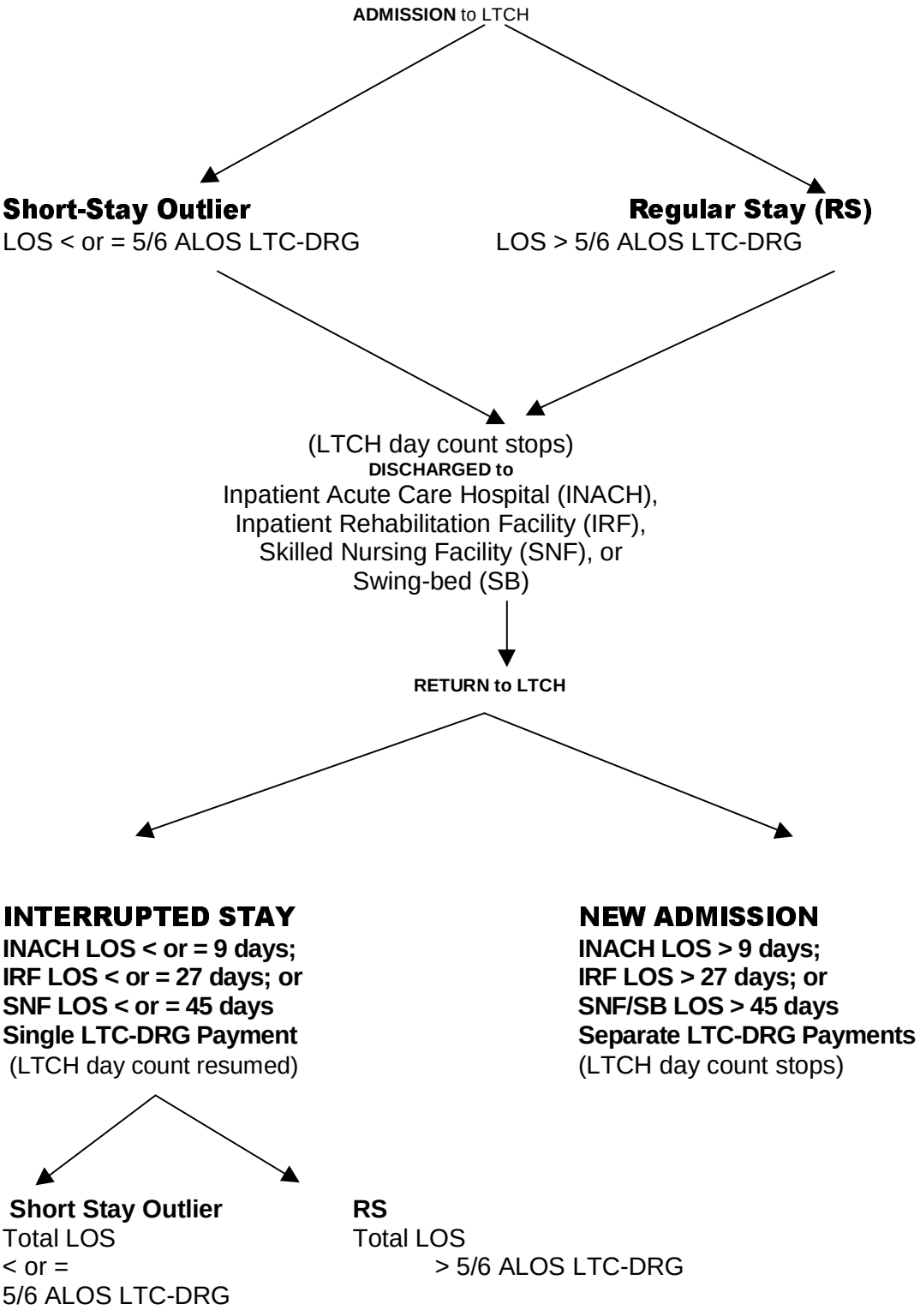
Payment Determination

Payments for short-stay outliers are determined in the PRICER logic.

Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. The flow chart on the next page describes the order that will be used to assess whether or not the adjustments apply. For example, a case may be a short-stay outlier and also be an interrupted stay.

SHORT-STAY OUTLIERS AND INTERRUPTED STAYS



High Cost Outlier Cases

Additional payments will be made for high cost outlier cases. These are cases that exceed the high cost outlier threshold.

High Cost Outlier Threshold

The high cost outlier threshold is the LTC-DRG payment plus the current fixed-loss amount. If the estimated cost of the case is greater than the high cost outlier threshold an additional payment will be added to the LTC-DRG payment amount.

High Cost Outlier Threshold = LTC-DRG Payment + Fixed-loss Amount

Fixed-loss Amount

The fixed-loss amount is determined such that projected outlier payments are equal to eight percent of total Federal LTCH PPS payments. The FY 2003 fixed-loss amount is $24,450.

High Cost Outlier Payment

The high cost outlier payment will be 80 percent of the difference between the estimated cost of the case and the high cost outlier threshold.

High Cost Outlier Payment =
80% * (Estimated Cost of Case - High Cost Outlier Threshold)

Estimated Cost of Case

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio (CCR) obtained from the latest settled cost report.

Estimated Cost of Case = Medicare Allowable Charge * LTCH CCR

Note

No retroactive adjustments will be made to payments for high-cost outliers to account for changes in LTCHs hospital-specific cost-to-charge ratios.

Determining the Cost-to-Charge Ratio

This section describes the appropriate data sources for computing an overall Medicare hospital-specific cost-to-charge ratio for the purpose of determining short-stay outlier payments at §412.529 and high cost outlier payments at §412.525(a) under the LTCH PPS.

FIs will use the latest available settled cost report and associated data in determining each LTCH's overall Medicare cost-to-charge ratio. The FI will then calculate updated ratios each time a subsequent cost report settlement is made.

As discussed in the August 30, 2002 final rule (67 FR 56026), retrospective adjustments to the data used in determining outlier payments will not be made.

The LTCH PPS payment includes operating and capital-related costs and excludes the costs of bad debts, medical education, nurse anesthetist, and blood clotting factors, which are paid for on a reasonable cost basis.

Total Medicare Charges

Total Medicare charges for LTCHs will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital).

Total Medicare Costs

Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only.

For LTCHs, overall Medicare cost-to-charge ratios will be based on the latest settled cost report data unless such data are either unavailable or outside the ranges noted below.

New Providers or Unreasonable Value

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period.

Use the appropriate urban or rural statewide operating and capital average.

If the overall Medicare cost-to-charge ratio cannot be calculated (i.e., "new" LTCHs) or is not reasonable, the appropriate urban or rural statewide operating and capital average calculated annually by CMS under the IPPS and published in the *Federal Register* should be summed and used.

For FY 2003, the statewide average operating and capital cost-to-charge ratios can be found in Tables 8A and 8B of the August 1, 2002 Hospital Inpatient PPS final rule (67 FR 50263).

For "new" LTCHs, use the IPPS statewide averages until the LTCH's actual cost-to-charge ratio can be computed using the first settled cost report data, which will then be used for the subsequent cost reporting period. As stated above, when the statewide average cost-to-charge ratios are used, the LTCH's cost-to-charge ratio will not be retrospectively adjusted based on later data.

Equitable Distribution of Outlier Payments

To ensure that the distribution of outlier payments remains equitable, an LTCH's overall Medicare cost-to-charge ratio is **considered not to be reasonable** if the value exceeds the combined (operating plus capital) upper (ceiling) and lower (floor) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the *Federal Register*.

For FY 2003, the combined operating and capital upper limit is 1.421 (1.258 plus 0.163) and the combined operating and capital lower limit is 0.206 (0.194 plus 0.012) (see August 1, 2002, 67 FR 50125). If the overall Medicare cost-to-charge ratio appears not to be reasonable, the fiscal intermediary should ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average.

Provider Specific File

The Provider Specific File contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the LTCH PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for LTCHs will be entered on the provider specific file only in Field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

Calculating the Cost-to-Charge Ratio

Under the LTCH PPS, an overall Medicare CCR is calculated as follows: Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). Total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101). Divide the Medicare costs by the Medicare charges to compute an overall Medicare cost-to-charge ratio.

CCR= Medicare Costs÷Medicare Covered Charges

Facility-Level Adjustments

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include *"…appropriate adjustments to the long-term hospital payment system..."*

Variables examined for use included an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME). There was no empirical evidence to indicate the need for rural location, the geographic reclassification, DSH or IME adjustments.

Wage Adjustment

The system will include an area wage adjustment that will be phased in over five years. The wage adjustment will be made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.

Wage Adjustment = Labor-Related Share of Standard Federal Rate * Wage Index Value

Wage Index

The wage index is being phased-in over five years.

The standard Federal rate is adjusted for differences in area wages by multiplying the labor-related share by the applicable wage index value based on the physical location of the LTCH (i.e., no reclassification). For FY 2003, the labor-related share is **72.885 percent**.

For FY 2003 the applicable wage index value is 1/5 the value of the pre-reclassification (no floor) hospital inpatient wage index without regards to reclassification.

COLA

The standard Federal rate will also be adjusted by a cost-of-living adjustment (**COLA**) for LTCHs located in Alaska and Hawaii by multiplying the non-labor-related portion of the standard Federal rate by the applicable COLA factor from the Office of Personnel Management based on the county in which the LTCH is located. For FY 2003, the non-labor-related share is **27.115 percent**.

For FY 2003, the COLA factors are:

AREA	COLA
Alaska:	
All areas	1.25
Hawaii:	
Honolulu County	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawaco County	1.2375

Co-located Providers:

Only one LTC-DRG payment will be made to the LTCH for all such discharges during that cost reporting period once the threshold has been reached.

There is a special payment policy for co-located providers. CMS established this policy to discourage patient-shifting among Medicare Providers that share a physical location.

A co-located LTCH is a long-term care hospital that occupies space in a building used by another provider, or in one or more entire buildings on the same campus of buildings used by another provider. An LTCH may be free standing and there may be other Medicare providers with that LTCH as either satellite facilities or hospitals-within-hospitals. The LTCH itself may also be a satellite facility or a hospital-within-a-hospital.

Hospital-Within-A-Hospital

Definition

A hospital-within-a-hospital is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

An LTCH that exists as a hospital-within-a-hospital, that is, it shares space with a separate acute care hospital, is considered co-located with that acute care hospital, as are on-site rehabilitation and psychiatric hospitals or units, swing-beds or skilled nursing facilities (SNFs).

A hospital-within-a-hospital must meet the criteria at CFR 412.22 (e) to qualify for exclusion from the IPPS unless it exempted in CFR 412.22 (f) which is basically a 'grandfathering clause' for hospitals exempted from IPPS on or before September 30, 1995.

CFR § 412.22 (e) Criteria

To be exempt from IPPS, a hospital-within-a-hospital must:

Have a separate governing body, chief executive officer, chief medical officer, and medical staff and meet one of the following criteria:

1. Perform basic functions independently from the host hospital,
2. Incur no more than 15 percent of its total inpatient operating costs for items and services supplied by the hospital in which it is located, **or**
3. Have an inpatient load of which at least 75 percent of patients are admitted from sources other than the host hospital.

Satellite LTCH Provider

Definition

Satellite providers are a hospital-within-a-hospital type facility that is owned by separate, existing LTCH.

LTCHs have established satellites that share space in a building or on a campus occupied by another hospital in order to establish additional locations that are an excluded hospital (specifically an LTCH). These additional LTCH locations may be either freestanding hospitals or hospitals-within--hospitals.

For these providers to be excluded from the acute care hospital PPS, a LTCH satellite must meet all the criteria in CFR §412.22(h).

Given these requirements, providers will need to maintain separate utilization statistics for the satellite. This does not mean that the numbers cannot be combined for cost reporting and billing, but the beds, days, and discharges for patients treated in the satellite have to be tracked separately in a way that can be verified by audit, to comply with the satellite rules.

CFR §412.22(h) Criteria

To be excluded from IPPS, a satellite of a hospital must:

1. Must maintain admission and discharge records that are separately identified from those of the hospital in which it is located;

2. Cannot commingle beds with beds of the hospital in which it is located;

3. Must be serviced by the same fiscal intermediary as the hospital of which it is a part;

4. Must be treated as a separate cost center of the hospital of which it is a part;

5. For cost reporting purposes, must use an accounting system that properly allocates costs and maintains adequate data to support the basis of allocation,

6. Must report costs in the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as that hospital,

7. Must independently comply with the qualifying criteria for exclusion from the acute care hospital inpatient prospective payment system; and

8. The total number of State-licensed and Medicare-certified beds (including those of the satellite facility) for a hospital that was excluded from the acute care hospital inpatient prospective payment system for the most recent cost reporting period beginning before October 1, 1997, may not exceed the hospital's number of beds on the last day of that cost reporting period rehabilitation needs.

9. For cost reporting periods beginning on or after October 1, 2002, a satellite facility may not be under the authority or control of the governing body or chief executive officer of the hospital in which it is located.

10. Furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.

Co-location and Provider Numbers

An LTCH satellite facility has the **same** provider number as it's controlling hospital but different from the hospital in which it is located.

A hospital-within-a-hospital has a **separate** provider number from its host hospital, but in fact may actually exist as one or more floors within the host building.

Co-location Payment Policy

If the rate of discharges and readmissions between the LTCH and a co-located provider exceeds five percent, only one LTC-DRG will be payable to the LTCH for all such discharges and readmissions during that cost reporting period. There are two distinct five percent thresholds:

ON-SITE ACUTE CARE HOSPITAL:

If during a cost reporting period an LTCH readmits more than five percent of its patients who were discharged to an onsite acute care hospital, only one LTCH-DRG payment would be made to the LTCH for all such discharges and re-admittances during that cost reporting period once the threshold has been reached.

ON-SITE SNF, SWING-BED, IRF OR PSYCHIATRIC FACILITY:

If during a cost reporting period more than (a separate) five percent of the LTCH patients are discharged to an on-site SNF, swing-bed, IRF, or psychiatric facility and then readmitted to the LTCH, only one LTC-DRG payment would be made to the LTCH for all such discharges during that cost reporting period once the threshold has been reached.

Prior to exceeding any of these five percent thresholds, discharges from and readmissions to LTCHs will be evaluated under the interrupted stay policy. Payments under this policy will be determined at cost report settlement. Further instructions will be forthcoming.

Notify Your FI Regarding Co-location Status

LTCHs will be required to notify their FIs and CMS regional office about the providers with which they are co-located within 60 days of their first cost reporting period that begins on or after October 1, 2002.

Changes in co-located status must also be reported to the FIs within 60 days of such events. The implementation of the on-site policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs will notify the CMS Regional Office of such arrangements.

Transitioning to the Federal Rate

LTCH PPS will gradually change from a blend of payments under the TEFRA system and the Federal rate to a full 100 percent Federal per-discharge LTC-DRG based prospective payment.

LTCH PPS will be phased in over a **five-year transition period** from cost-based reimbursement to Federal prospective payment, based on their cost reporting period beginning on or after October 1, 2002.

Payment is based on an increasing percentage of the LTCH payment and a decreasing percentage of its cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	LTCH PPS Federal Rate Percentage	TEFRA Rate Percentage
October 1, 2002	20	80
October 1, 2003	40	60
October 1, 2004	60	40
October 1, 2005	80	20
October 1, 2006	100	0

LTCHs are allowed a one-time irrevocable opportunity to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment.

To exercise this option, for cost reporting periods beginning on or after **October 1, 2002 and before December 1, 2002**, the LTCH must notify its FI of this election in writing. The notification must and be received by the FI no later than November 1, 2002.

To exercise this option, for cost reporting periods beginning on or after **December 1, 2002**, the LTCH must notify its FI in writing 30 days prior to the start of the LTCH's next cost reporting period.

New LTCH Providers and the Transition Period

A new LTCH is defined as a hospital that has its first cost reporting period as an LTCH beginning on or after October 1, 2002.

New LTCHs will not be eligible for the blended transition payments; new LTCHs will be paid based on 100 percent of the Federal rate.

Note:

Under the BIPA, during cost reporting periods beginning during FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the cost reimbursed portion of transition payments.

Periodic Interim Payment (PIP)

LTCHs may elect to be paid using the periodic interim payment (PIP) method described in CFR Part 42 §413.64(h), and may be eligible to receive accelerated payments as described in §413.64(g).

LTCHs that choose not to elect to receive PIP payments or those who are not qualified to receive PIP payments may continue to bill on an interim basis (see *Chapter 4–Billing* for more detail).

The PIP amount is based on the transition blend for those LTCHs that elect to be paid during the five-year transition based on the blended transition methodology for cost reporting periods beginning on or after October 1, 2002.

The PIP amount is based on the estimated prospective payment for the year rather than on the estimated cost reimbursement for those LTCH providers who are paid based on 100 percent of the standard Federal rate.

Please Note:

Outlier payments that are payable upon submission of a discharge bill are not included in the PIP amounts.

Beneficiary Liability

Beneficiary liability will operate generally the same as under the previous TEFRA payment system. Once a stay triggers a full LTC-DRG payment, the beneficiary cannot be billed for the difference between Medicare payments and the cost of care, even if the Medicare payment is below the cost of care.

Beneficiaries (or their Medigap insurance) are still responsible for all noncovered days. This is the same policy as exists under the previous TEFRA system.

Beneficiaries may only be charged for:

Deductibles

Coinsurance (days 61-90)

Lifetime reserve days coinsurance

Noncovered services (i.e., telephone and television, etc.)

Services furnished and not covered under Medicare due to benefits being exhausted or no entitlement to Part A

Beneficiaries can also be charged when an LTCH receives less than the full LTC-DRG payment as in the case of a short-stay outlier.

Provider can charge the beneficiary for:

- Deductible
- Coinsurance (days 61-90)
- Lifetime reserve days coinsurance
- Any items and services provided during stay not covered on the basis of the short-stay outlier payment

Sample Scenarios - Full LTC-DRG:

Once a stay triggers a full LTC-DRG payment (i.e., it exceeds the short-stay outlier threshold described later), Medicare will pay for the entire stay up to the high cost outlier threshold the same way it as it does under the IPPS, regardless of patient coverage. **However**, Medicare will pay only for covered days for lengths of stay equal to or below 5/6 of the average length of stay for a specific LTC-DRG.

For an LTC-DRG where the ALOS is 30, 25 days (5/6 of 30) would be the short-stay outlier threshold. If a patient's stay is 25 days or less, Medicare will pay it as a short-

stay outlier. So, if for example, a patient has only 15 remaining days of Medicare coverage and stays 24 days in the LTCH, Medicare will only pay for 15 days. However, if the patient has 27 days remaining, a full LTC-DRG will be payable since the stay has exceeded the short-stay outlier threshold and now will generate a full LTC-DRG payment which will constitute Medicare payment until and unless it becomes a high cost outlier. See Table 2.1 for illustration of this and other examples.

Once the beneficiary's stay reaches the 5/6 short-stay outlier threshold and receives the full LTC-DRG payment, consistent with IPPS, the remaining "inlier" days of the stay (and associated charges) are considered covered until the high cost outlier is reached even though the beneficiary is not using any Medicare covered days. Once the beneficiary reaches the high cost outlier threshold, the beneficiary may choose to use the lifetime reserve (LTR) days.

Using Lifetime Reserve Days

In the case of a stay that is categorized as a short-stay outlier for payment purposes (because the patient has run out of regular benefit days prior to exceeding the short-stay outlier threshold of 5/6 of the ALOS for the specific LTC-DRG), the remaining days of the patient's stay will be counted towards the beneficiary's lifetime reserve days (in the absence of an election not to use them) for the remainder of the episode of care, that is, until either the patient is discharged or the lifetime reserve days are exhausted.

Once a beneficiary starts using lifetime reserve days, each remaining day of hospitalization for that episode of care will be counted against those reserve days, even if no additional Medicare payments are generated until the high cost outlier threshold is reached.

High Cost Outlier Benefit Days

Consistent with the policy under IPPS, Medicare will pay for high cost outlier payments only for covered days, that is, days for which the beneficiary has either regular benefit days or lifetime reserve days for the period (or portion) of the stay beyond the high cost outlier threshold.

Sample Scenarios – LTR Days

Beneficiary "A" is admitted to the LTCH with 26 remaining days of regular Medicare coverage and is grouped to an LTC-DRG with an ALOS of 30 days. "A" has sufficient regular benefit days to trigger a full LTC-DRG payment (5/6 of the ALOS for that LTC-DRG) for this stay without going into lifetime reserve days. "A" would only need to consider using lifetime reserve days should the stay become a high cost outlier.

Beneficiary "B" is grouped to the same LTC-DRG as "A" but has only 10 remaining days of regular Medicare coverage. Lifetime reserve days will be used for the entire remainder of the stay (unless "B" elects not to use them and to otherwise assume responsibility for payments) and the day count will continue, uninterrupted, until the patient is either discharged or the days are exhausted.

Table 2.1 Beneficiary Liability Scenarios

ALOS of LTC-DRG	*Short Stay Outlier Threshold (5/6 of ALOS)*	*Actual Length of Stay*	*Payable as Short Stay Outlier*	*Benefit Days Available (Full/ Co/LTR)*	*LTR Used Assuming patient elects to use if needed.*	*Medicare-Payable Days*
30	25	25	Yes	0/15/30	10	25
30	25	20	Yes	0/15/30	5	20
30	25	27	No	0/15/30	12	27
30	25	29	No	0/25/30	4	29
30 Beneficiary "A"	25	35	No	0/26/30	0	35
30	25	45	No	0/26/30	0	45
30 Beneficiary "B"	25	35	No	0/10/30	25	35

Part B Ancillary Services Payment Under LTCH PPS

Current payment methodology continues to apply for Part B ancillary services.

Remittance Advices

Reason and remark codes already in existence for inpatient hospital PPS will apply under LTCH PPS.

Medicare Summary Notices and Explanation of Medicare Benefits

Existing Medicare Summary Notice messages will be used for LTCH PPS coverage.